Cervical cerclage technique: Towards agreement? An interim summary of a Delphi consensus of UK experts.

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Introduction

Transvaginal cervical cerclage is reported to be performed in around 1-2% of pregnancies and there is little consensus on technique. We have recently demonstrated a large variety in practice among UK cerclage experts, may partly explain the wide variety of outcomes in clinical studies with a potential impact on patient care, research and education. This study aimed to provide a UK consensus opinion on cerclage technique.

Methods

A working group formed of individuals with specialist interest in preterm birth from several hospitals designed a first round Delphi consensus questionnaire.

- Participants were asked to describe their usual practice
- Sent to all experts who had participated in our previous study

Agreement was set at 75%, with rate of agreement=(agrees-disagrees)/(agreement+disagreement+uncertainty)x100.

Results

20 experts participated in the survey with 19 completing all questions:

- Years of experience as a consultant ranged from 2-26 years, and time spent dedicated to preterm birth ranged from 10-100% of the total workload (Figure 1)
- Most commonly, participants (n=8) reported performing <10 cerclages/year, with three performing >50/year (Figure 2).
- 11 experts reported being able to perform both high and low cerclage (defined as with/without bladder reflection), all others reported being able to perform low only
- Two experts reported preferentially performing high cerclage, and were excluded from further data-analysis relating to intra-operative technique

There was **agreement** that non-traumatic forceps should be used to grasp the cervix, and that a four bite, single low cerclage as high as achievable on the cervix with at least 70% tension (on visual analogue score) through an anterior knot should be performed, and that removal should be ≥36 weeks' without routine regional anaesthesia; it was agreed that tocolysis and postoperative antibiotics should not be offered following a non-emergency cerclage. There was **no agreement** on other aspects of peri-operative care (eg. catheter use), concurrent progesterone, follow-up care, or management of subsequent PPROM.

Discussion

In this first round Delphi, a consensus agreement can be reached on some aspects of surgical technique, there are differences in the care women receive. The high rate of consistency in described intraoperative technique contrasts with our previous findings analysing actual expert technique on a simulator. While best technique is unclear, it must be recognised that women are receiving a variety of practices. The significance of variation requires further evaluation. Furthermore, this stands to highlight surgical technique as a confounder in all research, even when described. Finally, this raises concerns around the consistency of educational standards.

Respondents

Figure 1

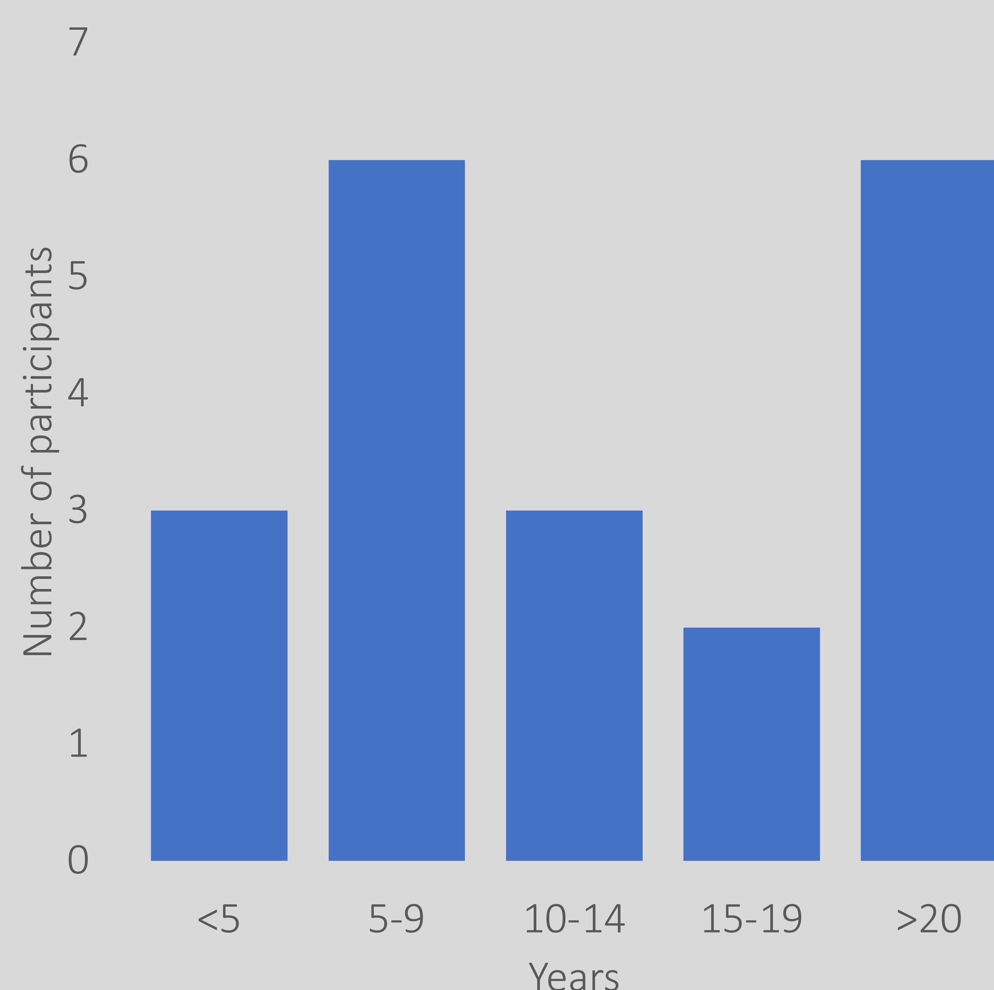
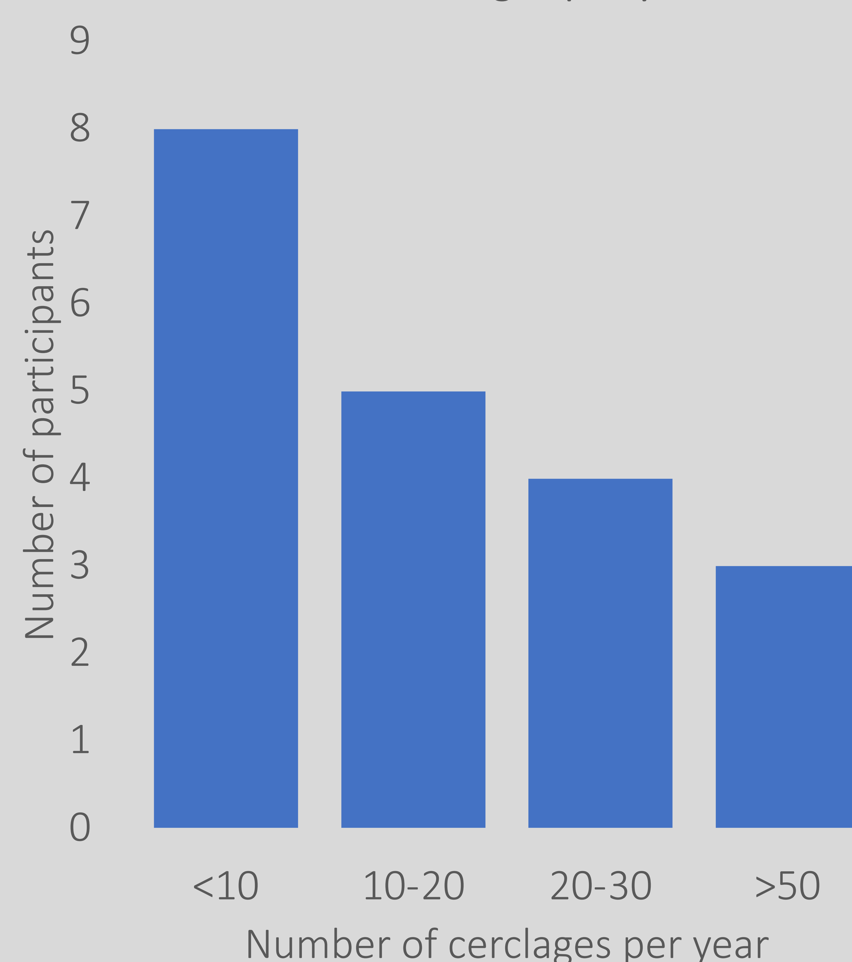
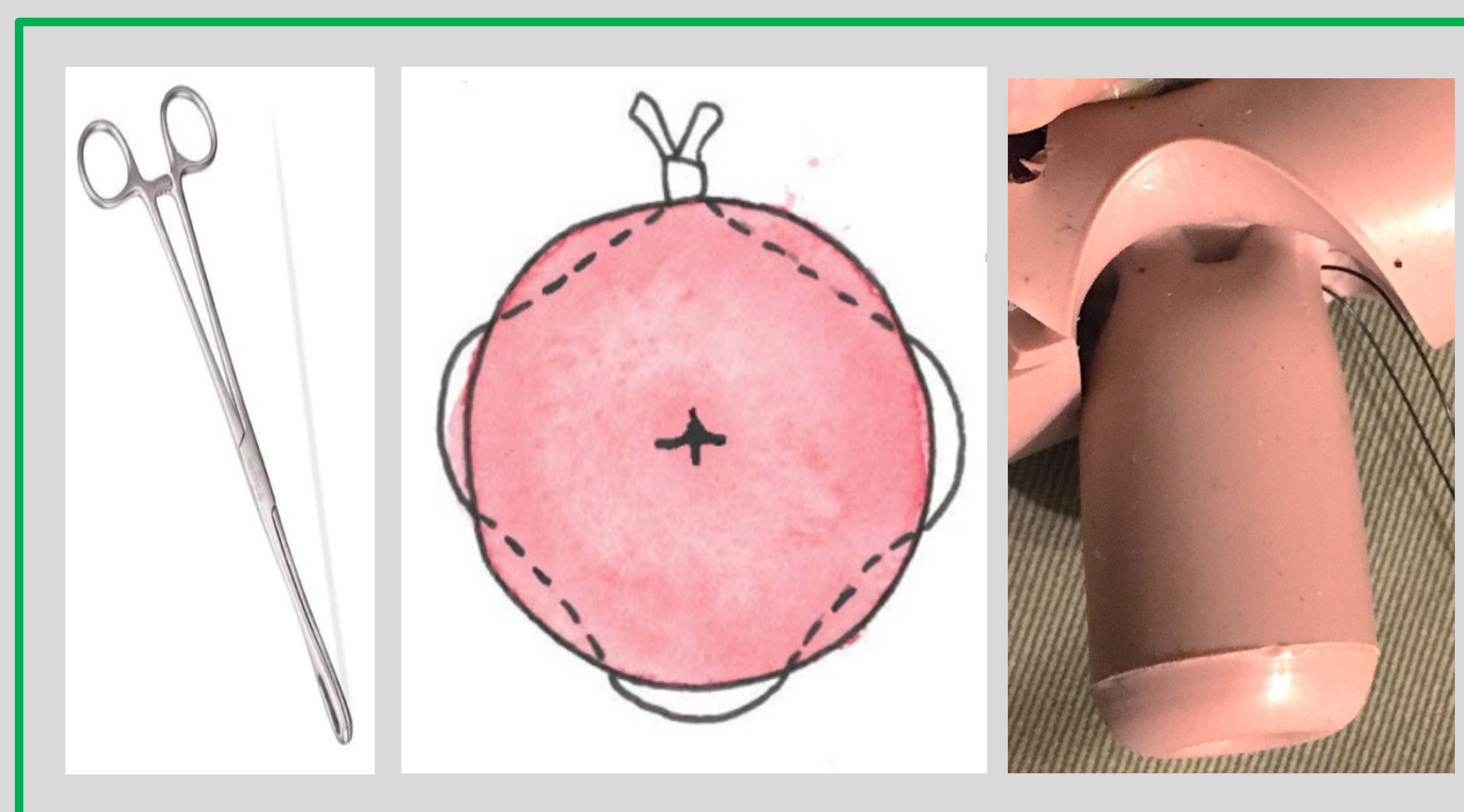


Figure 2



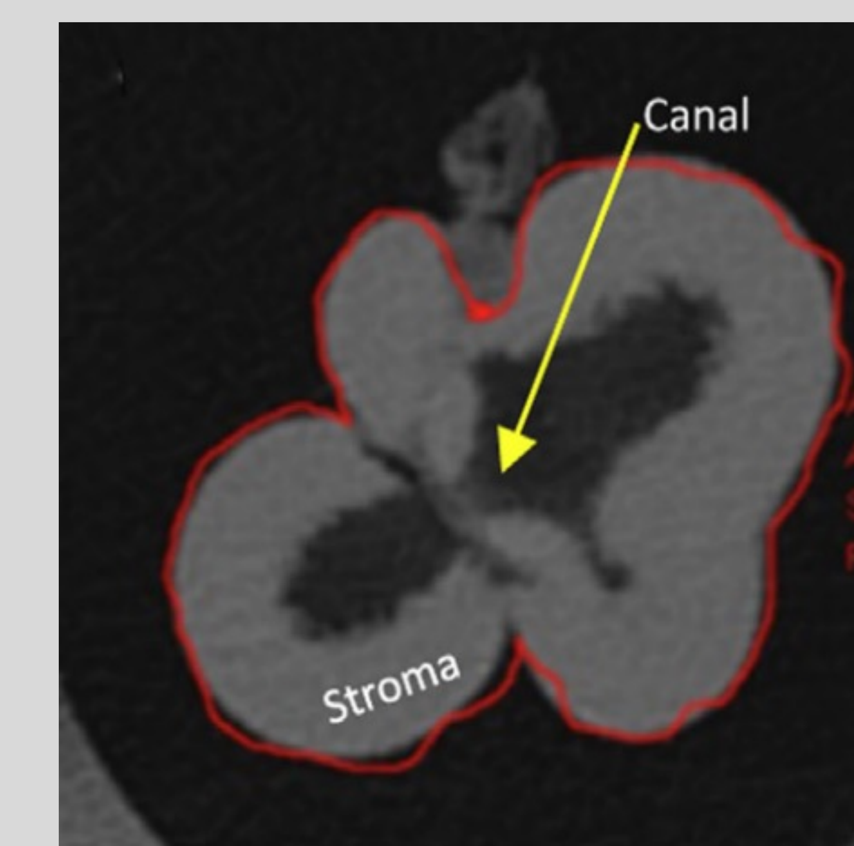
Results



No agreement:

- Other surgical issues
- Perioperative care
- Concurrent progesterone
- Follow-up care

Thoughts for the future



Ethical approval: MRSP-22/23-38437.